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No. 80-1952

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

Petitioners

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS

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Questions Presented

1. Should the Court of Appeals have determined the due process rights of Medicaid patients in nursing homes who are transferred from one level of care to another by their private physicians or nursing homes or from a lower to a higher level of care by federally-mandated Utilization Review Committees when no named respondent, intervenor or representative class member alleged that he had been, or imminently would be, subject to such a transfer?

2. Is the transfer of a patient from one level of care to another, by a private physician or other private party, affected by state action solely because the patient is Medicaid-funded and one result of the transfer is a change in the amount of benefits paid on his behalf?*

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* The petition for a writ of certiorari presented four questions for review. Petition p. i. The writ was granted on questions 1 and 2. October 5, 1981 Order in Docket Number 80-1952.

Parties in the Court Below

The caption of this proceeding lists the parties in the court below except that David Axelrod, M.D., as Commissioner of the New York State Department of Health, has been added as a petitioner and Robert Whalen, M.D., a defendant-appellant below individually and as Commissioner of the New York State Department of Health, has been dropped. Dr. Axelrod succeeded Dr. Whalen as Commissioner of the New York State Department of Health on January 2, 1979 and is substituted for him under Rule 25(d)(1) of the Federal Rules of Civil Procedure. No relief was awarded against Dr. Whalen individually.

Reference to petitioner Barbara Blum individually has been deleted from the caption of this proceeding. Mrs. Blum succeeded Carmen Shang as Commissioner of the New York State Department of Social Services on November 7, 1977 and was substituted for him under Rule 25(d)(1) of the Federal Rules of Civil Procedure. No relief was awarded against Mrs. Blum while she was named in that capacity.

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BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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Opinions and Judgments Below

The order of the Court of Appeals denying petitioners' request for rehearing of the opinion and judgment on review is not reported. The order is reproduced at A. 260-61.*

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* References preceded by "A." are to the joint appendix filed in this proceeding.

The opinion and judgment of the Court of Appeals on review is reported at 629 F.2d 817. It is reproduced at A. 245-59.

The district court memorandum opinion endorsed and partial final judgment that was affirmed in part, vacated in part and modified by the opinion and judgment on review are not reported. The memorandum opinion endorsed is reproduced at A. 240, and the partial final judgment is reproduced at A. 241-43.

Other reported opinions and judgments in the record on appeal are at 592 F.2d 65 (reproduced at A. 122-33) and 456 F. Supp. 653 (record on appeal document number [hereafter "R.A. Doc. No."] 59*).

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* Documents not reproduced in the joint appendix are cited to the record on appeal. See Rules 23(2) and 30(2) of the Supreme Court Rules. The record on appeal is designated by Court of Appeals docket number 80-7197. It includes the records on appeal in earlier and later Second Circuit appeals in this case. The earlier appeal, No. 78-7077, affirmed a preliminary injunction (A. 99-103) insofar as appealed. 592 F.2d 65, A. 122-33. The later appeal, No. 80-7559 (with cross appeal No. 80-7625) from an order dated June 9, 1980 (R.A. Doc. No. 114), was withdrawn. The Clerk of the Court of Appeals has marked the 80-7559 record on appeal as the second supplemental record on appeal in 80-7197 although it was not docketed as part of the 80-7197 record while that appeal was pending. See Court of Appeals Docket Entries from March 12, 1980 (receipt of notice of appeal in 80-7197) through August 25, 1980 (Court of Appeals judgment in 80-7197 filed). A. 17. With the exception of respondents' motion for stay of the partial final judgment on appeal in 80-7197 (R.A. Doc. Nos. 106, 107) and the district court opinion (R.A. Doc. No. 115 pp. 13-14) and order (R.A. Doc. No. 114 ¶ 6) denying that motion, the 80-7559 record does not contain any proceedings on review.

The document numbers of all the substantive district court proceedings in the 80-7197 record on appeal, as they should appear in the Clerk of the Court of Appeals transmittal to this Court, are shown in the second column of the District Court Docket Entries. A. 1-16. Proceedings in No. 78-7077 and No. 80-7559 are so identified in the Docket Entries (*Ibid.*) and in this brief when appropriate to enhance clarity.

Other unreported district court opinions and memoranda in the record on appeal are dated January 10, 1978 (reproduced at A. 104-20) and June 9, 1980 (R.A. Doc. No. 115 in 80-7559).

Numerous unreported district court final orders and judgments are in the record on appeal. Substantive final orders and judgments are dated November 30, 1977 (reproduced at A. 40-42), December 13, 1977 (reproduced at A. 43-46), January 5, 1978 (reproduced at A. 99-103), January 10, 1978 (R.A. Doc. No. 25), February 17, 1978 (reproduced at A. 121), July 31, 1978 (R.A. Doc. No. 65), October 3, 1979 (R.A. Doc. No. 85), October 17, 1979 (reproduced at A. 227-39), May 7, 1980 (R.A. Doc. No. 113 in No. 80-7559), June 9, 1980 (R.A. Doc. No. 114 in No. 80-7559) and June 13, 1980 (R.A. Doc. No. 116 in No. 80-7559).

Jurisdiction

Jurisdiction is conferred on this Court by 28 USC § 1254(1).

The order of the Court of Appeals denying petitioners' request for rehearing of the opinion and judgment on review was filed on February 18, 1981. A. 260. The opinion and judgment of the Court of Appeals on review was filed on August 25, 1980. A. 17 (docket entry for 8/25/80), A. 245. The petition for a writ of certiorari, Docket Number 80-1952, was filed on May 19, 1981. See 28 USC § 2101(c); Rule 20(2), (4) of the Supreme Court Rules.

Statement of the Case

Respondents Yaretsky, Cuevas and the Gray Panthers, New York Chapter, commenced this action against the Commissioner of the New York State Department of Social Services on July 28, 1976 in the United States Dis-

trict Court for the Southern District of New York. District Court Docket Entries for 7/28/76 and 11/4/76, A. 1; R.A. Doc. Nos. 1, 3.* According to the First Amended Complaint, Yaretsky and Cuevas were patients in the American Nursing Home in New York City, and the cost of their care was paid by medical assistance or "Medicaid." A. 20-21 ¶¶ 3, 4; A. 25 ¶ 20.** In December 1975, American's Utilization Review Committee ("URC") decided that neither respondent needed the skilled nursing ("SNF") care American provided and that each should be transferred to a lower level of care in a health related

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* The Commissioner of the New York State Department of Health was added as a defendant in the First Amended Complaint, dated February 9, 1977. A. 34.

** Medical assistance is an example of "cooperative federalisim" which permits participating states, like New York, to obtain federal aid ("FFP") to assist them in meeting the cost of medical care for the needy. States must operate their programs under approved state plans and comply with all federal requirements. 42 U.S.C. § 1396a. Under these requirements, individuals demonstrate their eligibility for assistance in terms of income and resources. 42 U.S.C. § 1396a(a)(10); New York Social Services Law ("SSL") § 366 (conforming state requirement). They can then obtain covered services, which include medically necessary long term care in skilled nursing facilities ("SNFs") and intermediate care facilities, denominated health related facilities ("HRFs") in New York, from any qualified providers they choose. 42 U.S.C. §§ 1396a(a)(23), 1396d(a)(4)(A),(c), (f); 10 New York Code, Rules and Regulations ("N.Y.C.R.R.") § 360.29. See 42 U.S.C. §§ 1395x(j), 1396a(a)(28), 1396d(i) (qualifications for SNF providers); 1396d(c) (qualifications for HRF providers); and New York Public Health Law ("PHL") §§ 2801(1)-(3), 2801-a; 10 N.Y.C.R.R. Parts 414-416, 420, 421 (conforming state requirements). Providers are, in turn, paid directly by state Medicaid authorities for the reasonable cost of care under that established reimbursement rates. PHL 2807(3); 10 N.Y.C.R.R. Subpart 86-2; *Sigety* v. *Ingraham*, 29 N.Y. 2d 110 (1971). HRFs provide less intensive care than SNFs (10 N.Y.C.R.R. §§ 416.1, 416.2, 421.2), and they are generally lower in cost. A. 169 ¶ I (12); A. 247.

facility, or "HRF." A. 25-26 ¶¶ 20, 21.* New York City social services officials, then responsible for administering certain long term care aspects of Medicaid, prepared to conform with the URC decisions by reducing the nursing home benefits paid on the respondents' behalf to the amount appropriate for the HRF provider or by discontinuing those benefits if American and the respondents did not follow the URC decisions. A. 25-26 ¶ 21.** State

* Utilization control, or review, is a federally mandated program which assists in the delivery of medical services to the individuals who need them in a cost-efficient manner. A requirement for effective utilization review and related FFP sanctions was added to the Medicaid program in 1972 by Pub. L. 92-603, 86 Stat. 1379. See 42 U.S.C. § 1396b(g)(1),(i)(4) and related amendments to § 1396a(a)(28) and (a)(30). Federal implementing regulations were not promulgated until November 29, 1974. 39 (231) Fed. Reg 41604-41608 (hospitals); 4160-41618 (SNFs and ICFs/HRFs). They are now codified 42 C.F.R. Part 456.

Utilization review is "peer review" of medical professionals by medical professionals. Every facility has its own URC which is appointed by the facility's management. SNF URCs must consist of at least two physicians, neither of which may be responsible for the care of the patient under review. HRF URCs must consist of at least one physician who may not be responsible for the care of the patient under review. 42 C.F.R. § 456.406. URCs periodically review continued patient stays to determine if the level of care being provided is appropriate. Each SNF patient must be reviewed every 90 days after an initial stay of 30 or 90 days, depending on the manner of admission (42 C.F.R. §§ 456.333, 456.334), and each HRF patient, every six months. 42 C.F.R. § 456.434. The URC must inform the patient under review and his attending physician, among others, if it decides to transfer the patient to a different level of care, and it must afford the attending physician an opportunity for comment. 42 C.F.R. §§ 456.336(f), 456.337, 456.436(f), 456.437. If the patient's attending physician disapproves of the transfer, two URC physicians must concur in it for it to become effective. 42 C.F.R. §§ 456.336(h), 456.436(h). Medicaid pays the providers the cost of URC services attributable to Medicaid patients within the limits of the reimbursement rates the state has established.

** New York State took over New York City's Medicaid responsibilities for nursing home care on April 15, 1977 (R.A. Doc. No. 16 [Williams affidavit], and the City defendant, joined early in the action (A. ¶ 12) was dismissed for that reason. A. 100 ¶ 1; A. 119-20. Prior to the state takeover, City Medicaid authorities reviewed URC continued stay decisions transferring

(footnote continued on following page)

social services officials affirmed the potential discontinuance of nursing home benefits after administrative fair hearings were afforded the two respondents. A. 26 ¶¶ 23, 24.*

According to the same complaint, the Gray Panthers, New York Chapter, was an association of 5,000 members, including Medicaid patients in nursing homes. A. 21 ¶ 5.

(footnote continued from preceding page)

patients to lower levels of care and approved or disapproved them. R.A. Doc. No. 16 (Baldwin affidavit ¶¶ 6-10). The state abandoned this practice and does not approve (other than by reason of the rulings below) or disapprove URC continued stay decisions. A. 148 (Maddaloni deposition).

* State Medicaid authorities initially opposed fair hearings following URC transfers to lower levels of care and questioned HEW (now HHS) on the point in an exchange of letters and telegrams which took place between March and July of 1976. R.A. Doc. No. 20 (Exhibits B-F to Steibel affidavit). In substance, the state argued that the URC regulations did not provide for another tier of review beyond the two URC physicians required to oppose an attending physician (discussion, p. 5 footnote); that both federal and state fair hearing requirements on reductions or terminations of assistance referred to 'agency action' as the cause for the reduction or termination of assistance and the social services agency, not a URC, was the agency contemplated; that the fair hearings, intended to review questions of individual eligibility based on income and resources, were not appropriate vehicles for reviewing the appropriateness of medical treatment; and that the provision of a fair hearing, particularly if current benefit levels were to continue until it was decided, opposed the URC purpose of timely transfers of patients to the levels of care suited to their medical needs. HEW's final response states in part (R.A. Doc. No. 16 [Exhibit F to Steibel affidavit]): "While the application of the fair hearing regulations to State agency actions based on Utilization Review Committee determinations may not be the most reasoned approach to the questions raised by Utilization Review determinations, they [including aid continuing] are nonetheless applicable." The state Medicaid authorities then conformed their program requirements, first with respect to notice and fair hearing rights and then, after the disposition in *Feld* v. *Berger*, 424 F. Supp. 1356 (S.D.N.Y. 1976), with respect to the timeliness of notice and aid continuing. See 10 N.Y.C.R.R. § 360.33.

HEW's position that fair hearings are required following URC transfers that result in reduction or terminations of benefits is also set forth in "All State Letter No. 76-4," dated February 10, 1976, included as an Exhibit to this brief. As there stated (p.2), no fair hearing rights are available to a patient whose own physician transfers him with the same result.

The association alleged that its members had been, or would be, injured by transfers like those planned for Yaretsky and Cuevas and that its objectives, advocacy of its members' rights and quality health care for the elderly, had been, or wouldd be impaired. A. 21 ¶¶ 5-7. The only additional substantive reference to the Gray Panthers during the proceedings below is in petitioners' Answer to the First Amended Complaint which acknowledges the Yaretsky and Cuevas transfers (A. 36-37 ¶¶ *Eighth, Ninth*) and otherwise denies the material allegations (A.35-37), including the description of the Gray Panthers and its status as a proper party. A. 35 ¶ *Third;* A. 37 ¶ *Fourteenth.*

The ten intervenors-respondents joined the action between November 28 and December 13, 1977. R.A. Doc. No. 57 Item 2 (Foley); A. 41 ¶ 2 (Wolper, Schulman, Rossoff, Ashkenazy); A. 45 ¶ 1 (Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy). According to their complaints, the URCs of the nursing homes in which Foley, Birenzweig, Zahl and Kolman were patients had decided that these intervenors did not need the SNF care the nursing homes provided and that they should be transferred to lower levels of care in HRFs. A. 49 ¶ 12, A. 50 ¶ 17 (Foley); A. 76 ¶ 12, A. 77 ¶ 18 A. 78 ¶ 22 (Birenzweig); A. 79-80 ¶ 28, A. 80 ¶ 33, A. 81 ¶ 37 (Zahl); A. 82-83 ¶ 44, A. 83 ¶ 49, A. 84 ¶ 53 (Kolman). The URCs of the nursing homes in which Wolper, Shulman, Rossoff, Ashkenazy, and the Lundys were patients had decided that these intervenors did not need the HRF care the nursing homes provided and that they should be transferred, or, more accurately, discharged, to adult homes. A. 58 ¶ 12, A. 58-59 ¶¶ 17, 21 (Wolper); A. 61 ¶ 30, A. 62 ¶ 35 (Shulman); A. 65 ¶ 46, A. 66 ¶¶ 52, 53 (Rossoff); A. 68 ¶ 64, A. 69 ¶¶ 70, 74 (Ashkenazy); A. 85-86 ¶ 60, A. 86 ¶ 65, A. 87 ¶ 69 (J. Lundy); A. 88 ¶ 75, A. 89 ¶ 80, A. 90 ¶ 84 (P. Lundy).* Each intervenor

* New York certifies voluntary and proprietary "adult homes" which provide care for individuals who "by reason of physical or other limitations . . . [are] unable to live independently," 18 N.Y.C.R.R. § 485.2. See also 18 N.Y.C.R.R. Part 486 (operating certificates); Part 487 (transfers). The care includes "personal-

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had been afforded a state fair hearing, and the determination to discontinue Medicaid nursing home benefits if the nursing home provider and intervenor did not follow the relevant URC decision had been affirmed. A. 51 ¶ 20, A. 52 ¶ 27 (Foley); A. 77-78 ¶ 21, A. 78-79 ¶ 24 (Birenzweig). A. 81 ¶ 36, A. 81-82 ¶ 40 (Zahl); A. 84-85 ¶¶ 52, 56 (Kolman); A. 59 ¶ 20, A. 60 ¶ 26 (Wolper); A. 63 ¶ 39, A. 64 ¶ 42 (Shulman); A. 66 ¶ 55, A. 67 ¶ 60 (Rossoff); A. 69 ¶ 73, A. 70 ¶ 78 (Ashkenazy); A. 86-87 ¶¶ 68, 71 (J. Lundy); A. 89-90 ¶¶ 83, 86 (P. Lundy).* A class was certified on December 13, 1977 when the last (Birenzweig) group of intervenors joined. A. 45 ¶¶ 1, 2.** No person, organization or 'class representative' other than the respondents and intervenors just described was before the court during any of the proceedings below.

The First Amended Complaint alleged that the planned URC transfers of Yaretsky and Cuevas from SNF to HRF care violated their rights under the Due Process Clause of the Fourteenth Amendment, Title XIX (Medical Assistance) of the Social Security Act, 42 USC § 1396 *et seq.* and related federal regulations. A. 19-20 ¶ 1. More specifi-

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care services, supervision of attendants and other . . . services as are necessary to assure health, safety and well-being." *Ibid.* However, it is not considered medical or nursing care. As a result, adult homes are not qualified Medicaid providers and tranfers to their facilities are discharges from a medically oriented system to a non-medically oriented one.

* The URC transfers of the respondents and the interveners to lower levels of care were not in fact accomplished. Yaretsky and Cuevas apparently were not transferred because of the pendency of the lawsuit. All the intervenors obtained temporary restraining orders (A. 41-42 ¶ 4 [Wolper group]; A. 45-46, ¶ 3 [Birenzweig group]; R.A. Doc. No. 57 item 2 [Foley]), and an injunction was entered thereafter A. 100-102 ¶ 2.

** The class was denied as all SNF and HRF patients in New York "who, following utilization review recommendations and/or fair hearings, are determined by defendants [petitioners] to be ineligible to receive the level of care at the facilities in which they reside and to be subject to [transfers to lower levels of care, or discharges, and to] reduction or termination of their Medicaid benefits." A. 45 ¶ 2. See also January 10, 1978 preliminary injunction opinion certifying a sub-class of these patients who were denied adequate notice of the reasons for their transfers and access to documents and evidence prior to their fair hearings. A. 118.

cally, respondents claimed that URC transfers to lower levels of care and the corresponding reductions in Medicaid benefits were arbitrary and incorrect evaluations of patient needs and were decided by improperly constituted URCs without adequate written criteria and without affording attending physicians an opportunity to comment. A. 26-29 ¶¶ 25-39; A. 29-30 ¶¶ 36-39. They claimed further that patients were denied adequate notice of URC decisions and the reasons supporting them and of their rights to and at fair hearings. A. 29-30 ¶¶ 37, 38; A. 31-32 ¶¶ 43-48. A claim of entitlement to the adoption and enforcement of a state policy requiring nursing homes to provide multiple levels of care, i.e. both SNF and HRF, in a single facility, allegedly eliminating the need for 'involuntary' patient transfers, was also pleaded. A. 30 ¶¶ 40-42.* Declaratory and injunctive relief and damages in the amount of one million dollars ($1,000,000.00) were sought. A. 32-33 ¶¶ 3-5. Jurisdiction was alleged under

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* The following sections of Title XIX, 42 USC, were cited in support: §§ 1396a(a)(3) (fair hearings required for individuals whose Medicaid claims are denied or not determined promptly); 1396a(a)(17) (reasonable standards required to determine eligibility and amount of assistance); and 1396a(a)(19) (safeguards required to assure that eligibility is determined and care and services provided consistently with simplicity of administration and the best interests of the patients). A. 28-29 ¶ 35(c)-(e); A. 30 ¶¶ 39(b), 42; A. 32 ¶ 3(a). The following sections of C.F.R., Title 45, were cited in support: § 205.10(a) (circumstances requiring administrative hearings for categorical assistance recipients and procedural rights); § 250.18 (Medicaid state plans must include a utilization control program to safeguard against unnecessary care and services); and § 250.19(a)(3) and (4) (SNF and ICF [HRF] utilization review procedures, including the composition and duties of URCs). A. 28 ¶ 35(a), (b); A. 30 ¶ 39(a); A. 31 ¶ 48(a); A. 32-33 ¶ 3(a), (d). 45 C.F.R. §§ 250.18 and 250.19(a) (3) and (4) have been recodified in 42 C.F.R. Part 456 (1980). See Redesignation Table II p. 813 and Redesignation Table III pp. 822-28 in 42 C.F.R. Part 400 to End (1980). Requirements that Medicaid state plans include utilization control programs are at 42 C.F.R. part 456 Subparts A and B (1980). Requirements for SNF and HRF utilization control, including the composition and duties of URCs, are at 42 C.F.R. Part 456 Subpart F (SNFs) and Subpart E (HRFs).

28 U.S.C. §§ 1331 and 1343 (3), (4). A. 20 ¶ 2. The intervenor complaints advanced essentially the same claims and sought the same relief. The Wolper complaint and the Birenzweig complaint (for J. Lundy and P. Lundy only) expand, and complete, the factual basis for the action by relying on URC transfers, or discharges, from HRFs to adult homes. See discussion, p. 7.*

On January 5, 1978, the district court issued a preliminary injunction on respondents' claims about patient notice of URC transfers to lower levels of care, including discharges to adult homes, the reasons supporting those transfers and the opportunity to contest them at administrative fair hearings. The injunction restrained petitioners, *inter alia,* from reducing or terminating Medicaid nursing home benefits for any class member, based on a URC decision that he did not need the level of care he was receiving, without (a) timely written notice to the patient, provided by state or local social services or health officials, advising him of the reasons for the URC decision, the proposed action of the social services officials to reduce or terminate benefits with citations to supporting regulatory authorities, and the patient's right to an evidentiary fair hearing and continuing benefits until his claim was decided administratively, and (b) written notice to the patient advising him of his right to examine

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* The following additional authorities are cited in support of the claims against URC discharges from HRFs to adult homes: 42 U.S.C. § 1396b(g)(1) (mandating decreases in FFP to states which do not have utilization control programs in effect); 45 C.F.R. §§ 249.10(a)(15) defining intermediate [HRF] care) and 249.12 (declaring patient rights not to be transferred or discharged from nursing homes except for medical reasons, the patients' welfare, the welfare of other patients or nonpayment). A. 72-73 ¶¶ 92, 95, 98, 101. Sections 249.10(a)(15) and 249.12 have been recodified in C.F.R., Title 42. See Redesignation Table II p. 813 and Redesignation Table III pp. 818-22 in 42 C.F.R. Part 400 to End (1980). Intermediate (HRF) care is defined at 42 C.F.R. 442.253 (1980); SNF patient rights are at §§ 405.1121(k), 442.202(c); and HRF patient rights, at § 442.311(c).

his case files and medical records before the fair hearing, including the material relied on by the URC and the material to be used against him at the hearing. A. 100-102 ¶ 2.*

Petitioners thereafter moved to alter or amend the injunction in two respects. R.A. Doc. Nos. 28, 29. They asked for (a) relief from the requirement that health or social services officials, rather than nursing homes or URCs, provide the mandated notices of reasons for URC decisions, corresponding reductions or terminations of benefits and fair hearing rights, and (b) permission to withhold medically contraindicated information from a patient during pre-hearing disclosure if the patient's physician decided that the patient should not be informed of his condition. *Ibid.***

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* The January 10, 1978 opinion in support of the injunction recognizes that the respondents' claims (except for the description of the reasons for the URC decision and the reasons for reduction or termination of benefits to be detailed in the patient notice) had been resolved in favor of similarly situated nursing home patients in *Feld* v. *Berger*, 424 F. Supp. at 1360-63 (timely notice and aid continuing); *id.* 1363 (access to case files and medical records, including potentially harmful, or "medically contraindicated" information) and adopts that opinion in relevant part. A. 112-13. The holdings on the injunction in this case and in *Feld* rely exclusively on the interpretation of federal and state regulations. A. 112, citing 45 C.F.R. § 205.10(a)(4)(i)(B) and 18 N.Y.C.R.R. § 358.8(a)—detailed written description of reasons for agency action required; *Feld* v. *Berger*, *supra*, citing 45 C.F.R. §§ 205.10(a)(4)(i)(A), 205.10(a)(4)(ii)(D), 205.10(a)(6)(i)—timely notice and aid continuing, citing § 205.10(a)(13)(i) and 18 N.Y.C.R.R. §§ 358.9(d), 358.12—access to case files and medical records. See discussion, p. 5 footnote. The due process claims in both cases are mentioned and characterized as not insubstantial. A. 114 (January 10, 1978 opinion); *Feld*, *supra*, at 1360 n.12.

** Compliance with the requirement that health and social services officials provide notices of the reasons for URC decisions, corresponding reductions or terminations of benefits and fair hearing rights meant that patients would receive two notices about URC transfers to lower levels of care, one mandated by the injunction, and one mandated by federal regulations which obligated URCs

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The district court denied the relief (A. 121), and petitioners appealed from the injunction, raising the two issues presented on the motion to alter or amend. A. 123-24. The Court of Appeals affirmed the district court. A. 125 (January 16, 1979 Court of Appeals Opinion). On the first issue, the majority held that federal regulations require two notices, one from URCs and another from state or local agencies responsible for the Medicaid program. The URC is to inform the patient about its decision to reduce the level of care he is receiving, a matter consistent with the doctor-patient framework in which the URC operates. A. 126-27 (relying on the regulations cited at p. 11, second footnote). The state or local public agency is to inform the patient that his benefits will be correspondingly reduced or terminated and of his fair hearing rights. A. 125, 126, 127 (relying on 45 C.F.R. § 205.10[a][4][i]). According to the majority, the state or local agency cannot delegate its obligation to notify, to a nursing home or URC, because the applicable regulations preclude delegation to private parties. A. 126. The majority states (A. 126 n. 2): "It [45 C.F.R. § 205.10 (a)(4)(i)] does not permit notice [for which public agencies are responsible] to be given by a private party or 'the Utilization Review Committee' of a private party." And further (*id.* n. 3): "45 C.F.R. § 205.100(b)(i) permits delegation 'by [to] other state or local agencies' but in

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to provide notice of their adverse decisions, i.e. 42 C.F.R. §§ 456.337, 456.338 (SNFs) (42 C.F.R. § 450.19[a][3][ix][G], [F] at the time of the motion); 456.437, 456.438 (IRFs) (42 C.F.R. § 250.19[a][4][vii][F], [G] at the time of the motion). A 'dual notification system' in effect prior to the injunction had been abandoned as confusing to the patients and inefficient. R.A. Doc. No. 28 Davidoff affidavit ¶¶ 3-7; *Id.* Skerrett affidavit ¶¶ 4-6, 8. The 'single notification system' petitioners preferred, required the nursing homes or URCs to incorporate notices of reductions or terminations of benefits and fair hearing rights in every URC notice of an adverse decision. R.A. Doc. No. 28 Davidoff affidavit ¶ 6; *Id.* Skerrett affidavit ¶¶ 6, 8.

no case permits delegation to a private party such as a health care facility or its 'Utilization Review Committee.' "* On the second issue, the full court held that medically contraindicated information was not exempt from the disclosure requirement of 45 C.F.R. § 205.10(a)(13)(i) and that its usefulness to a patient opposing a URC transfer to a lower level of care outweighed the risk that the patient's condition would deteriorate if he were fully informed. A. 128.

On March 5, 1979 the district judge signed a Pretrial Order which first raised the claims against the transfers in issue in this proceeding. A. 157 ¶ II(J); A. 166-67 ¶ II(J).** Private physician and nursing home transfers

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* The dissent on this issue interprets the regulations on which the majority relies differently and would permit a single notice to be provided by nursing homes or URCs A. 129-32. Section 205.10 (a)(4)(i) is read as requiring the state agency to retain only ultimate responsibility for timely and adequate notice of proposed action reducing or terminating Medicaid benefits, thus permitting any person or organization, whether public or private, to prepare and dispatch the notice. A. 130. Section 205.100(b) is read to foreclose the delegation of only discretionary acts to private parties, not the ministerial act of dispatching the state form notice with the URC notice. A. 130-31. Speaking in the alternative, the dissent describes the URC as a public agency (A. 130, 131-32), noting that § 205.100(b) would then have no foreclosing effect on its capacity to perform state-delegated tasks. A. 131-32.

** Extended discovery preceded the Pretrial Order. R.A. Doc. Nos. 35, 38-40, 44, 47, 48, 50-56, 60-63, 66-71. Over five hundred (500) URC decisions transferring patients to lower levels of care were produced (A. 198 ¶ XII [124]) and one hundred and fifty (150) fair hearings A. 204 ¶ XII (132). Ten (10) of the fair hearings (issued before December, 1978) considered the merits of URC transfers to higher levels of care. Petitioners objected to the production of patient records, other than those of the named respondents and intervenors, on the ground, *inter alia*, that they were confidential and privileged under federal and state law. R.A. Doc. Nos. 35, 61 pp. 3-6, 62 (McKay affidavit ¶¶ 3, 4). The district court responded to the objection by entering protective orders which limited access to patient records to respondents' and intervenors' attorneys and their assistants. R.A. Doc. Nos. 44 (second decretal paragraph); 56 (third decretral paragraph). See also R.A. Doc. No. 71 p. 3 (discovery sought subject to R.A. Doc. No. 44).

of Medicaid patients to different levels of care and URC transfers of these patients to higher levels of care were alleged to be improper under unspecified federal and state regulations prohibiting "arbitrary discharge" (A. 182 ¶ 61) and permitting nursing home transfers only for certain reasons which the Order did not set forth. A. 167 ¶ II(J)(b). They were also alleged to involve state action and to deprive patients of protected Fourteenth Amendment interests (transfers "down"—reduction or termination of Medicaid benefits; all transfers—"transfer trauma") if implemented without prior evidentiary hearings. A. 166-67 ¶ II(J).

The Pretrial Order describes the newly presented transfers only in terms of two of petitioners' policies then in effect. A. 180-82 ¶ IV. Patients transferred to different levels of care by private physicians and nursing homes were not entitled to fair hearings but could request one. A. 181-82 ¶ IV(60). If requested, the patient obtained the same rights, before and at the hearing, as a patient who contested a URC transfer to a lower level of care or to an adult home. A. 178-79 ¶ III(52); A. 181-82 ¶ IV(60).* Patients transfered to higher levels of care by URCs were not afforded fair hearings, at least since November, 1978 (A. 181 ¶ IV(57), (58[a]), and, since July, 1978, those URC decisions had been advisory, i.e. without prejudice to the patient's remaining at his pre-transfer level of care with corresponding Medicaid benefits in tact. A. 180

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* The October 17, 1979 Partial Final Judgment, Stipulation of Consent, enlarged the rights of URC transferees to lower levels of care to include a patient veto over "out-of-facility" transfers. A. 231-32 ¶ II(F)(2); A. 232-33 ¶ III(B). Since petitioners' policy provided private physician and nursing home transferees with the same rights as URC transferees to lower levels of care if the former requested fair hearings, both groups of patients could veto transfers to different nursing homes or adult homes.

¶ IV(56).*

The original claims of the respondents and intervenors about transfers to lower levels of care and discharges to adult homes which were originally pleaded and determined in their favor by the preliminary injunction and first appeal (discussion pp. 8-13) were restated in the Pretrial Order. A. 154 ¶ II[B], [C]; A. 164 ¶ II [B], [C].** The action was described as a class action brought on behalf of all Medicaid-eligible residents in nursing homes (A. 150 ¶ A), and a new class was defined, consisting of "all residents of skilled nursing and heatlh related nursing facilities in New York State who are recipients of Medicaid benefits." A. 151 ¶ B. No new respondent, intervenor or class representative was joined.***

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* The policies reflected the petitioners' informed judgment and were subject to their discretionary modification or repeal. For example, the policy permitting fair hearings for physician and nursing home transferees was under review when the Pretrial Order was signed. A. 181-82 ¶ IV (60). Petitioners' discretion in the premises was eliminated in the course of further proceedings in this case. Pre-transfer fair hearings were required, as a matter of constitutional right, for physician and nursing home transfers to different levels of care and for URC transfers to higher levels of care by the December 13, 1979 Partial Final Judgment (A. 242-43 ¶¶ 2, 4) and by the opinion and judgment on review A. 248-52. Voluntary tranfers, i.e those subject to patient veto, without prejudice to Medicaid benefits, were jeopardized by the discontinuance or reduction of FFP based on HEW's refusal to approve any state policy which gave Medicaid patients the choice of remaining at a level of care which was not URC prescribed. A. 217-20 ¶¶ 4-10. The October 17, 1979 Partial Final Judgment. Stipulation of Consent ¶ XIII (A. 236) and the opinion and judgment below (A. 252-53) respectively conditioned voluntary transfers and fair hearing rights on the judgment of HEW rather than of the petitioners.

** The original claim of entitlement to a state policy which would require nursing homes to provide both SNF and HRF care in a single facility (discussion, p. 9) was also restated. A. 152-53 ¶ I(B); A. 163-64 ¶ I.

*** The Pretrial Order included new claims in addition to those alleged against the transfers in issue herein. Medicaid patients

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Respondents and intervenors then moved for summary judgment on three distinct groups of claims. A. 209-11. The first group consisted of the claims against URC transfers to lower levels of care that were originally pleaded (except the claim involving SNF/HRF single facility care). See discussion, pp. 9, 15, second footnote. The entry of a Stipulation of Consent that had been executed by the parties (A. 229-36), or its equivalent, was sought. A. 209 ¶ 1(A)(1); A. 211 ¶ 1(B)(1). The Stipulation incorporated the relief previously awarded by the preliminary injunction (A. 232-33 ¶ III[A], [E]) and added certain substantive and procedural patient rights (A. 229-32 ¶ II; A. 232-33 ¶ III[A][2], [3], [B]-[D]), including

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transferred to lower levels of care were alleged to be entitled to: the assistance of trained patient representatives from notice of the URC decision and to counsel at fair hearings or other review proceedings, both at petitioners' expense; the presentation of a *prima facie* case at fair hearings, based on clear and convincing evidence, which would include proof that a URC physician had examined the patient and that no physical or psychological harm would result from the transfer; fair hearing decisions affirming URCs based on full review of transcripts and exhibits and precluding rejection of hearing officers' recommendations based on credibility; and independent review of URC decisions for at least facial or procedural defects by state or local public agencies. A. 153-57 ¶¶ II(A), (D), (E)-(H); A. 164-66 ¶¶ II(A), (D)-(H). Other claims which also were not originally pleaded alleged that to prevent bias and arbitrariness, a nursing home's URC physicians could not attend any patients in the home or any nursing home under the same management or ownership and that all URC and fair hearing procedures related to levels of care had to be promulgated as state rules or regulations. A. 157 ¶ II(I), (K); A. 166 ¶ II(I); A. 167 ¶ II(K). The claim about promulgation of procedures was determined, in part, in 1978 when the district court held that the numerical scoring system petitioners required URCs to use in conducting periodic reviews was a rule or regulation under state law (456 F. Supp. 653) and ordered it filed and promulgated accordingly. R.A. Doc. Nos. 59, 65. The claim about review of fair hearing transcripts and exhibits by the administrator affirming a URC transfer was decided with the claims against the transfers on review. See discussion, pp. 18, 19, 20.

a patient veto over URC transfers to lower levels of care and discharges "out-of-facility," i.e. to a different nursing home or to an adult home, which could be exercised without prejudice to the patients remaining at a higher level of care with the corresponding Medicaid benefits in tact. A. 231-32 ¶ II(F)(2); A. 232-33 ¶ III(B). It also listed issues which were reserved for future litigation (A. 234-35 ¶ VIII), including whether the transfers in issue in this proceeding involve state action and afford the affected patients a due process right to pre-transfer evidentiary hearings. A. 234-35 ¶ VIII(A)(1).* The presentation of the issue in this form eliminated claimed violations of federal and state regulations which were attributed to the transfers when they were first raised in the Pretrial Order. See discussion, pp. 13-14. On October 17, 1979, the district court granted the relief sought and adopted the Stipulation of Consent as a Partial Final Judgment. A. 227-28.**

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* The claim of entitlement to a state policy requiring nursing homes to provide both SNF and HRF care in a single facility was also reserved for future litigation (A. 235 ¶ VIII[B][3]), and the district court has not yet been asked to address it. The claim for one million dollars ($1,000,000.00) in damages was not settled or reserved.

** Petitioners opposed the adoption of the Stipulation of Consent on the ground that the express conditions to its entry had not been met. A. 218 ¶ 4; A. 219-20 ¶ 8. That condition, set forth in the Stipulation at ¶ XIII (A. 236), states that "judicial approval . . . shall not be sought by the parties until . . . [HEW] represents, or it is judicially determined, that defendants' [petitioners'] compliance . . . will not cause . . . [FFP] in the New York State Medicaid Program to be terminated or reduced. . . ." Although the attorneys for parties had requested HEW to provide the required representation, HEW did not (and still has not). A. 218-20 ¶¶ 5-9. Its only response was that program-wide reductions of FFP for non-compliance, if any, would be prospective and that retroactive reductions for non-compliance, if any, would be limited to individual cases discovered by audit. A. 218-19 ¶ 6. Petitioners found HEW's response insufficient (A. 219-20 ¶¶ 7, 8), particularly in light of their understanding that HEW was likely to find the Stipulation's provision for a patient veto out-of-com-

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The second group of claims relied on the transfers of Medicaid patients to different levels of care by private physicians and nursing homes and to higher levels of care by URCs which were first raised in the Pretrial Order. See discussion, p. 13. Declaratory and injunctive relief was sought on the Fourteenth Amendment rights of these patients to pre-transfer evidentiary hearings (A. 209-10 ¶¶ 1[A][2][a], [A][3][b]), the question about the transfers reserved for future litigation in the October 17, 1979 Partial Final Consent Judgment, Stipulation of Consent ¶ VIII(A)(1). A. 234-35. See discussion, p. 17. Declaratory and injunctive relief was also sought on a third group of claims. A. 210 ¶¶ 1(A)(2)(b), (A)(3)(c). They alleged that the fair hearing procedures permitting the administrator who issued the final decision to reject a hearing officer's recommendation in favor of a patient without reading a verbatim transcript of the hearing and the exhibits were constitutionally insufficient and violated state law. *Ibid.**

Both the second and third groups of claims were opposed by petitioners and litigated before the district court. A. 223-26. No new respondent, intervenor or class representative was joined during the proceedings. On

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pliance. A. 220 ¶ 10; A. 221 ¶ 12. Petitioners then moved to join HEW as a party so that the agency's position on the Stipulation, as well as the other claims on the motion, could be established and litigated, if necessary. A. 221-22 ¶¶ 12 *et seq.*; R.A. Doc. No. 85. The motion was denied. R.A. Doc. No. 85 (memorandum endorsed on back). In so ruling, the district court apparently relied on the portion of paragraph XIII of the Stipulation, which relieves the petitioners from part, or parts, of the agreement which HEW subsequently finds to be out-of-compliance and assumed that any interim losses of FFP would be minimal. Petitioners did not appeal from the adoption of the Stipulation of Consent as a Partial Final Judgment.

* This third group of claims, like the second, was first raised in the Pretrial Order. See discussion, p. 15 second footnote.

October 17, 1979, the district court decided both groups of claims adversely to petitioners. The court's memorandum opinion endorsed states in full (A. 240):

> "The Court holds that as to both non-UR transfers out of a facility or to a lower level of care and as to UR transfers to higher levels of care there is a due process right to a hearing, state action being involved in both instances for all the reason[s] set forth in plaintiffs['] [respondents and intervenors'] memorand[a] on these question[s] and that it is settled law that a verbatim transcript is required."

A (second) Partial Final Judgment followed on December 13, 1979. A. 241.* The judgment certifies a new class, first described in the Pretrial Order (discussion, p. 15), of "all Medicaid recipients in the State of New York who are residents of skilled nursing facilities or health-related facilities" located in the state. A. 241-42 ¶ 1. The declaratory relief awarded in favor of pre-transfer hearings omits the opinion's out-of-facility limitation and decrees that petitioners' failure to provide advance written notice and opportunity for prior evidentiary hearings for nursing home transfers of Medicaid patients to higher or lower levels of care and for their discharges from nursing care violates the Due Process Clause of the Fourteenth Amendment. A. 242 ¶ 2. The injunctive relief on this point directs petitioners and all persons in active concert with them (including skilled nursing and health related facilities and their personnel) to enforce the declared hearing rights and requires the pre-transfer hearing to determine "the validity and appropriateness" of the transfer. A. 243 ¶ 4. The judgment also includes declaratory and injunctive relief on the transcript issues. A. 242 ¶ 3; A. 243 ¶ 5.

Petitioners appealed the December 13, 1979 Partial Final Judgment and the denial of their motion to join

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* The December 13, 1979 Partial Final Judgment was not entered by the district court until February 19, 1980. A. 243.

HEW as a party. A. 244, 246.* The Court of Appeals affirmed the district court's holding that Medicaid patients transferred to different levels of care by their private physicians or nursing homes ("non-UR" or "non-URC" transfers [A. 241, 248]) and to higher levels of care by their URCs were entitled to pre-transfer evidentiary hearings under the Fourteenth Amendment. A. 248-52.** It modified the related injunction, which mandated written notice of and opportunity for prior hearings which would determine "the validity and appropriateness" of the transfers (A. 243 ¶ 4 and discussion, p. 19), by relieving petitioners of any obligation there stated which HEW found inconsistent with Medicaid program requirements. A. 246, 253, 259.*** The district court's holding on the transcript issue was found inconsistent with both federal and state law (A. 254-59), and the related portions of the judgment vacated. A. 246, 259.**** That Court's denial of petitioners' motion to join HEW was affirmed as not an abuse of discretion. A. 246, 252-53, 259.

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* A stay of the judgment's hearing and transcript requirements pending appeal was requested from the district court (R.A. Doc. Nos. 106 [Skerrett affidavit, McGarvey affidavit]; 107 pp. 12-20) and denied. R.A. Doc. Nos. 114 ¶ 6; 115 pp. 13-14.

** The Court excluded URC transfers to lower levels of care from consideration, recognizing that the October 17, 1979 Partial Final Judgment, Stipulation of Consent (A. 227), had settled the question of permanent relief left open by the Court's earlier (January 16, 1979) opinion. A. 248.

*** Respondents and intervenors cross-petitioned for a writ of certiorari on this Court of Appeals ruling. Docket Number 80-6890. They argued that it was clear error for the Court to have conditioned the due process rights of Medicaid patients on federal statutory or regulatory program requirements. Petition, p. 5. The petition was denied. October 5, 1981 Order in Docket Number 6890.

**** Respondents and intervenors petitioned for a writ of certiorari on this Court of Appeals ruling. Docket Number 80-5791. The petition was denied on February 23, 1981. 450 U.S. 925.

According to the Court of Appeals, private physician and nursing home transfers of Medicaid patients to different levels of care and URC transfers of these patients to higher levels of care were within the Fourteenth Amendment because they involve state action and deprive the affected patients of protected interests in liberty and property. A. 248-51. State action sufficient to satisfy the nexus requirement described in *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974), is said to be present because Medicaid benefits are adjusted to conform with the level of care selected by the patient's physician, nursing home or URC. A. 249-50.* Any other basis for finding state action present is expressly disclaimed, and the identity and private character of the individual or group transferring the patient is said to be irrevelant. *Ibid.* As the Court observes (A. 250): "[A]n alteration in the patient's benefits . . . is the nexus required by *Jackson* v. *Metropolitan Edison*, and . . . that exists . . . despite . . . [any] change in identity of the party initiating the transfer. . . ." However, the Court appears to take another, or perhaps, alternative approach, in its discussion of state action, characterizing the decision of a physician, nursing home or URC about the level of care a Medicaid patient receives as, "in essence," a delegation of the state decision to increase or reduce a public assistance recipient's benefits "to a 'private' party," and finds that the delegation cannot prevent due process guarantees from attaching. A. 249. The first Court of Appeals opinion in this case is cited in support of this proposition (A. 126-27, pp. 12-13), although it prohibited state and local officials from delegating their obligation to notify Medicaid patients about reductions in benefits to nursing homes and URCs. *Ibid.* Patient transfers to higher levels of care are then found to involve protected interest in liberty because of the risk of transfer

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* *Jackson's* finding of no state action is distinguished on the ground that the regulatory commission's failure to exercise its veto power in that case was "passive" 'inaction' whereas state Medicaid authorities in fact 'respond' to the choices of physicians, nursing homes and URCs when they adjust benefits. A. 249.

trauma, and transfer to lower levels of care, protected interests in property because of the consequential reduction or termination of Medicaid benefits paid on the patients' behalf. A. 250-51.* The Court concludes its review of the Fourteenth Amendment rights of Medicaid patients affected by the transfers in issue by finding that the pre-transfer evidentiary hearing required by the judgment on appeal (A. 242-43 ¶ 4) fairly defines the process that is due. A. 251-52.** At no point in the discussion of state action, the protected interests of the patients, or the procedures which satisfy due process does the Court consider whether any respondent, intervenor or class representative was transferred, or threatened with a transfer, to a different level of care by his physician or nursing home or to a higher level of care by his URC.

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* The holding in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), that transfer trauma is not a protected liberty interest is distinguished on the ground that the injury to the patients in this case is more direct and the record in support of the existence of the condition, better. A. 251.

** The Court's acceptance of pre-transfer evidentiary hearings in this context depends, in part, on its understanding that the affected patients are entitled to essentially the same hearing right under federal and state statutes and regulations. A. 252. See also A. 246 and A. 253, citing 42 U.S.C. § 1396(a)(3) and 45 C.F.R. § 205.10. This view is mistaken. As the Court's own reference to the cited statute and regulation at A. 247 makes clear, the provisions refer to hearings on reductions or terminations of assistance, excluding the physician, nursing home and URC transfers to higher levels of care to which the judgment (A. 242-43 ¶ 4) and this proceeding are directed in part. In addition, neither HEW nor state social services officials consider medical transfers by physicians and nursing homes to lower levels of care, or discharges, the only "downward" transfers considered by the judgment and in issue in this proceeding, to be subject to statutory or regulatory fair hearing rights even though they result in reductions or terminations of benefits. See discussion, p. 6, second footnote.

Summary of Argument

The district court was without jurisdiction under Article III to find that state action was involved in private physician or nursing home transfers of Medicaid patients to different levels of care, or in URC transfers of these patients to higher levels of care. No respondent, intervenor or class representative complained that he had been transferred, or threatened with transfer, in this manner, much less that he suffered, or would suffer, the requisite "distinct" or "palpable" injury. *Gladstone Realtors* v. *Village of Bellwood,* 441 U.S. 91, 99 (1979). The classes certified by the district court, whether narrowly or broadly defined, did not cure this jurisdictional defect. Since none of the named respondents or intervenors, who purported to represent the class, established the requisite case or controversy with the petitioners, none could seek relief for himself or anyone else. *O'Shea* v. *Littleton,* 414 U. S. 488, 494 (1974).

The physician, nursing home and URC transfers in issue are medical decisions about the intensity of nursing care a patient needs. They are made by a patient's attending physician, a staff physician at his nursing home or these physicians' "peer review" committee, the URC. The Court of Appeals correctly identified them as private decisions for all patients at the time they are made, regardless of the manner in which the patients intended to pay their bills if they accepted the medical advice. A. 249-50. The Court then transformed the medical decisions into decisions of the state if the patients were Medicaid-funded *and* the decisions about their care produced conforming adjustments in benefits to meet their cost. The Court's reasoning in this regard and, in particular, its adoption of an adjustment in benefits rationale to find state action present, is foreclosed by *Jackson* v. *Metro-*

politan Edison Co., 419 U.S. 345 (1974), the only case cited in its support. Moreover, the incongruous results that flow from it are manifold. Because there is no certain relationship between change in cost and care, much less one with a "close nexus" to the state, medical decisions of minimal significance, like a change in a druggist's prescription, involve state action, while others of great significance, like a surgeon's refusal to perform a potentially life-saving operation on cancer patient, do not. Indeed, the Court of Appeals rationale does not even permit the patients to whom it is specifically directed the relief they sought, and the Court apparently intended them to have. Since the cost of nursing home care and the level of nursing home care are not synonymous, the transfer of a Medicaid from an SNF to a HRF of equal cost does not involve state action although the intensity, or level, of nursing care changes. In like manner, the transfer of a patient between SNFs of unequal cost, does involve state action although the level of nursing care remains the same. Both results are exactly at odds with what the Court of Appeals intended to achieve, the protection of state action for changes in levels of care.

POINT I

The district court did not have jurisdiction to determine whether state action was involved in private physician or nursing home transfers of Medicaid patients to different levels of care or in Utilization Review Committee transfers of these patients to higher levels of care. No respondent, intervenor or class representative complained that he was either transferred or threatened with transfer in this manner.

The jurisdiction of the federal courts is limited to "cases [and] . . . controversies." U. S. Const. art. III, sec. 2. *Flast* v. *Cohen*, 392 U.S. 83, 94 (1968). The requirement is satisfied only by a plaintiff who demonstrates to the district court that he has actually suffered a "distinct or palpable injury" or has been so threatened as a result of the action challenged. *Gladstone Realtors* v. *Village of Bellwood*, 441 U.S. 91, 99 (1979). See also, *H.L.* v. *Matheson*, —— U.S. ——, 101 S. Ct. 1164, 1169 (1981); *Warth* v. *Seldin*, 422 U.S. 490, 501 (1975); *O'Shea* v. *Littleton*, 414 U.S. 488, 493-4 (1974); *Roe* v. *Wade*, 410 U.S. 113, 128 (1973); *Flast* v. *Cohen*, *supra*, at 101. In this proceeding, the actions challenged and the basis for the finding of state action in the opinion below (A. 249-50) and in the district court memorandum opinion endorsed (A. 240) were private physician and nursing home transfers of Medicaid patients from one level of care to another and URC transfers of these patients to higher levels of care. However, no respondent, intervenor or class representative complained that he had been transferred or threatened with transfer in this manner, and as a result, no case or controversy was presented to the district court.*

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* Article III defects in jurisdiction "may always be raised, even for the first time, at the Supreme Court level," L. Stern and

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The claims of the respondents and the intervenors were limited to URC transfers of Medicaid patients in nursing homes to lower levels of care and discharges from HRFs to adult homes. See discussion of the First Amended Complaint and the intervenor complaints at pp. 7, 8-10. Their claims were partially determined by the district court's preliminary injunction (A. 100-102 ¶ 2) which was affirmed, insofar as appealed, by the Court of Appeals in its first opinion in this case. A. 123, 125-129.* They were restated in the Pretrial Order (A. 154 ¶¶II [B], [C]; A. 164 ¶¶ II [B], II[C]), and finally determined by the October 17, 1979

(footnote continued from preceding page)

E. Gressman, Supreme Court Practice, 885 (5th ed. 1978) because "an actual live controversy must be extant at all stages of appellate or certiorari review, not merely at the time the complaint is filed. *Preiser* v. *Newkirk*, 422 U.S. 395, 401; *Steffel* v. *Thompson*, 415 U.S. 452, 459 n. 10; *Roe* v. *Wade*, 410 U.S. 113, 125; *SEC* v. *Medical Committee for Human Rights*, 404 U.S. 403; *United States* v. *Munsingwear, Inc.*, 340 U.S. 36." *Id.* 886.

* The preliminary injunction determined the claims of respondents and intervenors about notice to affected patients, to be provided by health or social services officials, of (a) the reasons for URC transfers to lower levels of care and corresponding reductions or terminations of Medicaid benefits, (b) fair hearing rights with aid continuing and (c) pre-hearing access to patient case files and medical records, including medically contraindicated information. A. 100-102 ¶ 2 (January 5, 1978 preliminary injunction order), A. 112-14 (January 10, 1978 preliminary injunction opinion) and discussion, pp. 10-11. Petitioners appealed from two aspects of the January 5, 1978 order: their obligation to provide a notice of the reasons for URC decisions and corresponding reductions of terminations of benefits which resulted in affected patients receiving two notices, one from their URCs or nursing homes, and one from the petitioners; and the patients' right of access to medically contraindicated information in their case files and medical records. A. 125-129 and discussion, pp. 11-13. The Court of Appeals affirmed the preliminary injunction in these respects. A. 123, 125-29.

Partial Final Judgment which was entered on consent. A. 232 ¶ III (A); A. 233 ¶¶ III (D), (E)).*

The transfers of Medicaid patients from one level of care to another by private physicians and nursing homes and to higher levels of care by URCs that are in issue in this proceeding were presented for the first time in the March 5, 1979 Pretrial Order (A. 157 ¶ II[J]; A. 163 ¶ 28; A. 166-67 ¶ II[J]; A. 180-182 ¶ IV) and due process (A. 163 ¶ 28; A. 180-82 ¶¶ 56, 57, 58, 59, 60, 61) and statutory violations of patients' rights there alleged, A. 157 ¶ II(J); A. 166-67 ¶ II(J). The question of whether state action was involved in these transfers was then stated and reserved for future litigation in the October 17, 1979 Partial Final Judgment (A. 234-35 ¶ VIII [A] [1]), although no respondent or intervenor complained that he had been, or would be, subject to any of these transfers, much less that he had suffered, or would suffer, a "distinct or palpable injury" as a result. *Gladstone Realtors* v. *Village of Bellwood, supra.* The district court determined the state action question as well as the related question of what process was due, while the case remained in this posture, namely without a party or any other representative be-

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* The October 17, 1979 Partial Final Judgment made the preliminary injunctive relief permanent. A. 232 ¶ III(A); A. 233 ¶¶ III(D), (E). It also finally determined the claims of respondents and intervenors about the reliability and regularity of URC decisions on transfers to lower levels of care (First Amended Complaint A. 26-29 ¶¶ 25-35; A. 29-30 ¶¶ 36-39 and discussion, pp. 8-10) by establishing certain substantive and procedural constraints for URCs (A. 29-31) and fair hearings (A. 233 ¶ IV and discussion pp. 16-19) and by omitting those claims from the issues reserved for future litigation. A. 234-35 ¶ VIII. Respondents' claim of entitlement to nursing homes with multiple levels of care, the only claim pleaded in the First Amended Complaint and intervenor complaints (A. 30 ¶¶ 40-42) to survive the October 17, 1979 Partial Final Judgment, was reserved for possible future litigation A. 235 ¶ VIII(B)(3). It is immaterial to this proceeding since it has yet to be addressed by the district court. See discussion, pp. 9, 17.

fore the court who complained about the transfers on which the ruling relied (A. 240 [memorandum opinion endorsed]; A. 242-43 ¶¶ 2, 4 [December 13, 1979 Partial Final Judgment]), and the Court of Appeals affirmed in relevant part. A. 249-252. See discussion, pp. 13-15, 17, 18-22. Given the absence of a party with a personal stake in the outcome of the proceedings just described, the case or controversy requirement was never satisfied for the private physician, nursing home or URC transfers.

The classes certified during the proceedings below did not cure the deficiencies in Article III jurisdiction. The original December 13, 1977 certification defined a class of individuals who were, or would be, subject to URC transfers to lower levels of care, and discharges to adult homes. A. 45 ¶ 2. This class definition was consistent with the claims of the named respondents and intervenors.* The class claims were finally determined in the October 17, 1979 Partial Final Judgment, together with those of the named respondents and intervenors, and are moot. See discussion, pp. 25-26.

The March 5, 1979 Pretrial Order described a new, broader class, which was intended to support the private physician and nursing home transfers to different levels of care and URC transfers to higher levels of care, at issue in this proceeding, as well as other new claims

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* The district court's January 10, 1978 certification of a subclass of individuals subject to URC transfers to lower levels of care, who had been denied adequate notice and access to documents and evidence prior to their fair hearings, (A. 118) was also consistent with the claims of the named respondents and intervenors.

raised in the Pretrial Order. A. 151 ¶ B and discussion pp. 15-16. The new class was incorporated in the December 13, 1979 Partial Final Judgment and defined as "all Medicaid recipients in the State of New York who are residents of skilled nursing facilities or health-related facilities in the State." A. 241-42 ¶ 2. No new respondent, intervenor or class representative was joined when the Pretrial Order was signed or entered and none was added before entry of the Partial Final Judgment. As a result, since the district court did not have before it any person with standing to raise the transfers at issue in this proceeding, the broader class definition could not cure the Article III jurisdictional defect. As the Court stated in *O'Shea* v. *Littleton, supra,* at 494, if none of the named respondents "purporting to represent a class establishes the requisite of a case or controversy with the defendants, none may seek relief on behalf of himself or any other member of the class." *Accord, Indiana Employment Division* v. *Burney,* 409 U.S. 540, 541-42 (1973); *Bailey* v. *Patterson,* 369 U.S. 31, 32-33 (1962).

The claims of the Grey Panthers, if any, were finally determined together with those of the original (December 13, 1977) class in the October 17, 1979 Partial Final Judgment.* The new class described in the Pretrial Order and incorporated in the December 13, 1979 Partial Final Judgment excluded the Grey Panthers relying exclusively on "residents of skilled nursing and health-related nursing facilities in New York State who are recipients of Medicaid benefits." A. 150 ¶ A; 151 ¶ B; 241-42 ¶ 2. Accordingly, the Grey Panthers was not a party in any of the proceedings which adjudicated the transfers on review.

Even if the Court finds that the Grey Panthers continued to be a viable respondent during the phase of the

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* See p. 27 footnote.**

litigation in which the transfers in issue were adjudicated, their allegations did not present the district court with a case or controversy either in its own behalf or as a representative of its members. A. 21 ¶¶ 5, 6, 7. The Grey Panthers' allegations in its own behalf relied on the association's interests in quality health care and advocacy for its members. A. 21 ¶¶ 5, 7. These allegations amount to a mere interest which is not sufficient by itself to "render an organization 'adversely affected' or 'aggrieved'. . . ." *Sierra Club* v. *Morton*, 405 U.S. 727, 739 (1972). Moreover, the Grey Panthers did not allege that the association had any statutory or constitutional rights which were violated. A. 21 ¶¶ 5, 6, 7. Its claimed capacity to litigate the constitutional rights of its members required it to show that its members, standing alone, had the requisite personal stake to meet the case or controversy requirement. *Warth* v. *Seldin*, 422 U. S. 490, 511 (1975). An "association must allege that its members, or any one of them, are suffering immediate or threatened injury as a result of the challenged action of the sort that would make out a justiciable case had the members themselves brought suit." *Ibid.*, quoting *Sierra Club* v. *Morton*, *supra* at 734-741. The Grey Panthers did not show that any of its members were transferred or threatened with private physician or nursing home transfers to a different level of care or URC transfers to a higher level of care. A. 21 ¶¶ 5, 6, 7. This Court's recent decision in *Grey Panthers* v. *Schweiker*, —— U.S. ——, 101 S. Ct. 2633, 2638, n. 8 (1981), permitting the Grey Panthers to raise the constitutional rights of its members, is not opposed. There, the Grey Panthers "alleged and proved that some of its members are [were] persons adversely affected. . . ." (*Ibid.*), exactly the proof missing in this case.

POINT II

Decisions by private physicians and nursing homes to transfer Medicaid patients to different levels of care and by utilization review committees to transfer these patients to higher levels of care do not become decisions of the State because the patients' benefits are increased or decreased, when warranted, to reflect differences in the cost of care.

The Court of Appeals found state action involved in the patient transfers in issue for only one reason—the adjustment in Medicaid benefits that follows a change in the level of nursing home care, or transfer, prescribed by a physician, nursing home or URC. A. 249-50. Two legal theories were offered to support the finding that state action was present. First, the "close nexus" between state and private action required by *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974), was said to be satisfied because the state "responds to" (A. 249) the decisions of the medical professionals when Medicaid authorities increase or decrease benefits to accommodate differences in the cost of care that result from the transfers. A. 247, 249-50. Second, the decisions of the medical professionals were said to be state-delegated decisions to increase or decrease benefits because they determined whether a conforming adjustment in Medicaid benefits would be made. The first theory is foreclosed by *Jackson* v. *Metropolitan Edison Co., supra,* the case the Court of Appeals relied on, and the second theory, by *Flagg Brothers, Inc.* v. *Brooks,* 436 U.S. 149 (1978).

The adjustment in benefits rationale adopted by the Court of Appeals does not evidence the "nexus" between state and private action with respect to the patient transfers in issue required by *Jackson,* and the state's involve-

ment in the transfers is both less than and distinguishable from that presented by the utility commission's approval of the tariff considered in that case. *Jackson* describes the required relationship between the state and the private party as follows (419 U.S. at 351): "[T]he inquiry must be whether there is a sufficiently close nexus between the State and the challenged action of the regulated [private] entity so that the action of the latter may be fairly treated as that of the State itself." As appears, the state action component of the private entity's conduct must be "the challenged action" or the subject matter of the complaint. *Powe* v. *Miles*, 407 F.2d 73, 81 (2d Cir. 1968) (FRIENDLY, C.J.); *Grossner* v. *Trustees of Columbia University*, 287 F. Supp. 535, 548 (S.D.N.Y. 1968). See *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715, 725 (1961). Under the Court of Appeals analysis in this case, it is not.

Respondents and intervenors do not complain about adjustments in their Medicaid benefits to meet the cost of their medical care, the only nexus between state and private action identified by the Court of Appeals. A. 249-50. They complain about the medical care itself, specifically the change in the level of nursing home care prescribed for them by their physicians, nursing homes and URCs. These medical decisions, which the Court of Appeals analysis accepts as private and free of state action in the first instance, are not "fairly treated" as acts of the state under *Jackson, supra*, because Medicaid authorities adjust the patients' benefits to meet the increased or decreased cost of the prescribed care. First, the adjustment in benefits is not an "action of the [private] entity," and respondents and inteverors do not 'challenge' it. Second, the adjustment in benefits has no effect on, or "nexus" with, "the action of the [private] entity" that is "challenged," namely the medical decisions that prescribe different levels of nursing home care, and those decisions therefore cannot be attributed to the state. The adjustment in benefits has no effect on the medical decisions

because it accepts the decisions in tact, without review of their merits or redetermination of their "validity or appropriateness." December 13, 1979 Partial Final Judgment, A. 243 ¶4(b). It provides only a conforming response, addressed to what the decision cost, an act which, as noted, is not challenged, is not the act of the private entity which is intended to be attributed to the state and is without effect on the acts complained of.

The Court of Appeals distinguished the no state action finding in *Jackson* on the ground that the state utility commission's approval of the tariff in that case was more "passive" than the Medicaid authorities' response in adjusting benefits to conform with the medical decisions of physicians, nursing homes and URCs about level or nursing home care their patients should receive. A. 249. The distinction finds no suport in *Jackson*, and the involvement of the state in the transfers in issue is less than was presented by the state utility commission's approval of the tariff in that case.

In *Jackson*, the Court set forth its reasons for refusing to find state action involved in the state utility commission's approval of a tariff which authorized the termination of customers' electrical service for nonpayment without a prior hearing (419 U.S. at 357):

> "Approval of [a termination of service provision] . . . from a regulated utility, where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmute a practice initiated by the utility and approved by the commission into 'state action.'"

Accord, *Flagg Brothers, Inc.* v. *Brooks, supra,* at 164, quoting text and describing it as supporting the Court's position that a state's mere acquiescence in private action does not convert that action into state action. *Flagg, supra,* at 164-65, notes further that the device of characterizing state inaction as authorization or encourage-

ment of private action so as to permit the imposition of Fourteenth Amendment restraints on the private action has been clearly rejected.

The application of this reasoning to the tranfers in issue must result in a finding that there is less state involvement in them than was present in the state utility commission's approval of the tariff in *Jackson*. According to the Court's opening remark in the text quoted above, the utility commission had approved the tariff, or at least had the power to approve or disapprove it on its merits. See also 419 U.S. at 354-55. Medicaid authorities do not exercise any similar power of "approval" with respect to physician and nursing home transfers to different levels of care and URC transfers to higher levels of care.* Nor do they put their "weight on the side of" the transfers by "ordering" them. As described above, the adjustment in benefits leaves the medical decisions in tact, without altering their form or substance, addressing them only in terms of their consequential cost. If the Medicaid patient were obliged to accept the prescription of his physician, nursing home or URC after the adjustment was made, the result in terms of state action analysis

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* Indeed, there is grave doubt that Medicaid authorities have the power to address the merits of medical decisions to transfer patients by determining their "validity and appropriateness" (A. 243 ¶ 4[b]) in the course of adjusting benefits. As the Court recognized in *Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52, 60 (1976), the state is without power to countermand the private medical choices of its citizens, at least in the absence of a clear threat to the public health, safety or welfare. Accordingly, it cannot have recourse to the device of increasing, decreasing or denying Medicaid benefits for that purpose. In the one circumstance, URC transfers to lower levels of care, in which Medicaid authorities in New York do determine the "validity and appropriateness" of medical decisions to transfer patients in the course of adjusting benefits, they were required to do so by HEW over their objection. See discussion, p. 6 footnote.

would be "mere acquiescence" of the state in the 'authorized,' or lawful, conduct of the physician, nursing home or URC, an insufficient basis for finding state action present. *Flagg Brothers, Inc.* v. *Brooks, supra; Jackson* v. *Metrolopitan Edison Co., supra.* However, he is not. Like any privately-funded patient, he may reject the medical advice he has been given and refuse the care. The only constraint on his choices is the same constraint faced by the privately-funded patient. He cannot obtain a medical service or level of care that a physician, nursing home or URC finds inconsistent with professional standards to provide.

The Court of Appeals alternative use of its adjustment in benefits rationale to find state action present in the transfers in issue because the medical decisions which prescribe them are, "in essence," state-delegated decisions to increase or decrease Medicaid benefits (A. 249) fairs no better than the use of that rationale under *Jackson.* Again, the Court confuses the decisions that are in issue with those that are not and confuses their effect on each other. The medical decisions about which respondents and intervenors in fact complain are made by physicians, nursing homes and URCs who, as the Court of Appeals recognized in both its opinions in this case, are private parties performing their traditional functions. A. 126 (January 16, 1979 Court of Appeals Opinion); A. 249-50 (opinion and judgment below). See discussion, pp. 12-13, 21. These decisions are not associated with the state at all, much less with a traditional or an exclusive function of sovereignity which would have to be present to support a finding in favor of state action on a delegation theory. *Flagg Brothers, Inc.* v. *Brooks, supra,* at 157-64 (refusng to find state action present in a warehouseman's execution of a lien and generally limiting the recognition of state action in private conduct, based on the delegation of state duties, to the performance of functions exclusively associated with government or sovereignity, e.g. elec-

tions, tax collection and municipal management); *id.*, at 171-79 (OPINION of STEVENS, J., dissenting and taking principal issue with the majority's refusal to include non-sovereign functions in the state action delegations it would recognize, a matter not here relevant). See *Schlein* v. *Milford Hospital, Inc.*, 516 F.2d 427, 429 (2d Cir. 1977); *Barrett* v. *United Hospital*, 376 F. Supp. 791, 799 (S.D.N.Y. 1974), *aff'd mem.* 506 F.2d 1395 (2d Cir. 1974); *Wagner* v. *Scheltz*, 471 F. Supp. 903, 907 (D. Conn. 1979); *Fuzie* v. *Manor Care, Inc.*, 461 F. Supp. 689, 695 (N.D. Ohio 1977); *Fried* v. *Straussman*, 41 N.Y. 2d 376, 376 (1977), all holding that while private and voluntary hospitals and nursing homes were affected by the public interest, they do not perform public functions traditionally associated with sovereignty. See also *Jackson* v. *Metropolitan Edison Co.*, *supra*, at 353-54.

The adjustment in benefits, about which respondents and intervenors do not complain, has no effect on the medical decisions transferring them (discussion, pp. 32-33, 34) and is not delegated. It is retained by the state Medicaid authorities and performed by them directly. This practice is required by the Medicaid program which includes adjustments in benefits in the determination of "the extent of medical assistance," 42 U.S.C. § 1396a(a)(17), a matter assigned to the single state agency and the public agencies it designates, not to private parties. The Court of Appeals relied on this principle of non-delegability of certain Medicaid program functions to private parties in its first opinion in this case. A. 126-28 and discussion, pp. 12-13. The Court then prohibited state Medicaid authorities from delegating the preparation and dispatch of patient notices about reductions in benefits and fair hearing rights on URC transfers to lower levels of care to physicians, nursing homes and URCs, describing them as private parties who were precluded from performing that public task by federal Medicaid regulations. *Ibid.* When the Court articulated its adjustment in benefits rationale

in the opinion and judgment on review, it nonetheless found that the same private parties had been delegated, and were free to perform, the more significant program function of adjusting patients' benefits. A. 125-27 and discussion, p. 21.

The rejection of the Court of Appeals finding that state action is involved in the transfer decisions in issue does not disadvantage Medicaid patients. It simply, and properly, discounts the source of their funding, leaving them with exactly the same rights and remedies as non-publicly assisted patients. In addition, the rejection of Court of Appeals ruling has salutary consequences for the Medicaid program. The judgments of the medical professionals are restored to the determinative position Medicaid intends them to have. See *Szekely* v. *Florida Medical Association.* 517 F.2d 345, 348 (5th Cir. 1975); *Rush* v. *Parham,* 440 F. Supp. 383, 388-91 (N.D. Ga. 1977). State Medicaid authorities are, in turn, relieved of the obligation to determine the "validity and appropriateness" (A. 243 ¶ 4[b]) of prescribed medical treatment, a matter outside Medicaid program requirements, and not the intended subject matter of fair hearings.

In contrast, the affirmance of the Court of Appeals finding results in extraordinary analytical and practical incongruities. Under the Court of Appeals adjustment in benefits rationale, decisions of Medicaid providers become "state action" decisions because they increase or decrease cost (and therefore benefits) without regard to their significance to the patient or to the state. Thus, the decision of a physician to change his patient's prescription from a "brand name" drug to a generic drug becomes a decision of the state because it minimally decreases cost. A decision of a physician to continue a cancer patient on chemotherapy does not, because cost (and benefits) continue to be the same. However, if the physician had decided, or decides in the future, that the same patient

should have surgery (increased cost, increased benefits) or should be withdrawn from chemotherapy (decreased cost, decreased benefits), his decision would involve state action. Notably, if the surgeon selected to perform the operation in the example above refused to do it, whether for arbitrary or medical reasons (and the patient were continued on this prior chemotherapy), no state action would be involved, because cost (and benefits) would remain the same. If the surgeon performed the operation, again whether for arbitrary or medical reasons, state action would be involved because cost (and benefits) would increase.

Indeed, under the Court of Appeals rationale, the class of Medicaid patients respondents and intervenors purport to represent do not obtain the relief they seek, and the Court intended to provide, namely the protection of state action for changes in levels of nursing home care, and discharges from that kind of care.

In New York, reimbursement rates for patient days (equivalent to the benefits paid on a Medicaid patient's behalf) are established for each individual SNF and HRF. PHL § 2807(3); 10 N.Y.C.R.R. Subpart 86-2; *Sigety* v. *Ingraham*, 29 NY 2d 110 (1971). Although rates for HRFs are "generally lower" than rates for SNFs (A. 169 ¶ 1[12]; A. 247), SNF and HRF rates vary within their respective classifications and across classifications. Thus, the rate of one HRF can be more, or less, than another, as can the rate of one SNF in comparison to another. Equally, the rate of an HRF can be the same as, or higher than, the rate of any SNF, and the rate of any SNF, the same as, or lower, than any HRF. As appears, this variable rate structure confounds the Court of Appeals adjustment in benefits rationale and disassociates a finding that state action is present from changes in the levels of care, the protective purpose the Court of Appeals intended it to have. The point is illustrated by the following patient transfers:

1) SNF to SNF, difference in rates/benefits, no difference in level of care—no state action present;

2) SNF to HRF, no difference in rates/benefits, difference in level care—no state action present;
3) HRF to SNF, no difference in rates/benefits, difference in level of care—no state action present"; and
4) HRF to HRF, difference in rates, no difference in level of care—state action present.

CONCLUSION

For the foregoing reasons, the Judgment below should be vacated as entered without jurisdiction, or, alternatively, it should be reversed, and physician and nursing home transfers of Medicaid patients to different levels of care and discharges from care as well as utilization review committee transfers of Medicaid patients to higher levels of care should be declared free of state action under the Fourteenth Amendment.

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